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Clark County Regional Support Network Policy Statement

Policy No.: 12

Policy Title: Care Termination Procedure

Effective Date: September 1, 2001

Policy: All CCRSN Contracted Providers' when discharging PHP consumers from services, shall have the termination of care adequately documented, clinically substantiated and, when required, prior approval by the RSN Clinical Care Manager.

Reference: WAC 388-865, Washington Administrative, Clark County RSN Contract, any other applicable RCW/WAC statutes or codes.

Procedure:

1. The provider will document the care termination of a PHP consumer through the IS system. Following are the corresponding definitions for the Reason for Closure:

   a) CODE 01 - Treatment Complete:
   If consumer/family and provider's designee agree that the consumer is no longer in need of mental health services at this time, a consumer's case may be closed as treatment goals have been achieved to a satisfactory level. The case notes in the consumer's chart should reflect progress toward goals, continuing community support resources, conditions for returning to treatment and should document the consumer's/parents verbal or written agreement that treatment goals have been achieved.

   b) CODE 02 - Consumer/family requests closure:
   If consumer/family requests termination of care, the provider's assigned clinician/designee is to inquire about reasons for the request and attempt to address any unresolved issues/concerns. The attempts are to be documented in the case notes.

   c) *CODE 03 - Consumer/family requests closure against medical advice:*
   If consumer/family requests case closure despite advice to the contrary from mental health professionals, the provider's assigned clinician/designee is to inquire about reasons for the request and attempt to address any unresolved issues/concerns. The attempts are to be documented in the case notes. Final termination will require prior approval from a RSN Care Manager.

   d) CODE 04 - Failure to return:
   This reason for care termination is to be used for individuals who fail to return for service after completion, updating, or modifying of a treatment plan. The provider, prior to termination, should make a concerted effort to re-engage the consumer/family through contact attempts by mail, phone, and/or outreach to last known place of residence/shelter. If contact is facilitated, problem solving should be attempted regarding any identified barriers to treatment including, but not limited to, transportation, family responsibilities,

work and school schedules, cultural barriers, financial problems, or conflicts with the provider's assigned clinician/case manager.

e) CODE 05 - Moved from Clark County:
If the consumer moves, the location, if known, is to be documented. The provider clinician/designee is to provide referrals and follow-up as appropriate to assure that referrals have been facilitated and there will be no lapse of services to address essential needs, e.g., medication prescriptions. If a consumer will be continuing in mental health services following the move, a copy of the termination summary should be made available to the new provider upon signed release by the consumer.

f) CODE 06 - Consumer deceased:
The RSN must be notified within 24 hours after provider agency is aware of a death of a consumer. A critical incident review should accompany the notification. (See RSN Policy: Critical Incident Review)

g) CODE 07 - Transferred to another PHP Mental Health Agency:
Transfers between agencies within the PHP are be reviewed and authorized by a RSN Clinical Care Manager prior to initiation of transfer, e.g., an adolescent reaching the age of eighteen and in need of transition to adult services contracted through another provider under the RSN Clark County Contract.

If the transfer is planned by an Agency – the Agency referring is required to contact RSN within 30 days to discuss the case and provide assurances that the record and care coordination will be transferred in a timely fashion.

If a consumer presents at an agency and requests services instead of the current provider - the Agency receiving the consumer is required to contact RSN within 30 days to discuss the case and provide assurances that the record and care coordination will be transferred in a timely fashion.

h) CODE 08 - Client not engaged in services:
This is to be checked if a consumer has completed intake but terminated from services prior to completion of the individualized treatment plan.

i) CODE 09 - Assessment Only:
If the agency were providing an assessment only, this category should be checked.

j) CODE 10 - Other (describe):
Indicate whatever other reasons a consumer may be terminating services.

k) CODE 11 - Referred to chemical dependency treatment

l) CODE 12- Does not meet financial and/or clinical criteria

m) CODE 13 - Immenent Services Only

n) CODE 14 - Crisis Services Only

o) CODE 15 – Transfer to Non-PHP Agency

2. Provider designee/clinician must also complete the appropriate Level of Functioning tools consistent with the authorization type and enter the information in Functional Criteria Data Screen at care termination.

3. Provider designee/clinician must also update client's address and phone number on the information system.

4. Prior approval, by a RSN Clinical Care Manager, for termination is required when any of the following circumstances exists:

   a) A complaint or grievance is in progress
   b) A termination of care that is involuntary or contested by the consumer
   c) A consumer is requesting closure against medical advice
   d) A consumer is being transferred to another RSN Contracted Agency

5. To expedite the care management conversation, please be prepared to discuss the items outlined below; additionally, the following detail of a consumer's termination is required to be present in the case record in an organized written format.

   a) Reason for closure.
   b) Progress made toward treatment goals.
   c) Summarization of efforts to engage family members/significant others.
   d) Supports in place to be used to support consumer after discharge.
   e) Summarization of DSM IV Axis IV Psychosocial Environmental Problems at Termination with documentation of plans for consumer to address unmet needs.
   f) Unusual Events or Extraordinary Occurrences regarding the consumer. Medications or health concerns at termination, if any.
   g) Plans for consumer to address health or medication needs.
   h) Identification of the most recently involved agency and service component/program.
   i) Referrals made on termination and other ongoing community support resources available to consumer.
   j) Documentation, if a wrap-around team exists, as to whether or not all members agreed to termination. If not all members are in agreement but termination is to proceed, then documentation is required regarding opinion differences of the involved team members.
   k) Recommendations for treatment should the consumer desire to return to services in the future, particularly if the consumer was involuntarily terminated or non-compliant with the individualized service plan.
   l) Summarization of problem solving regarding any identified barriers to treatment including, but not limited to, transportation, family responsibilities, work and school schedules, financial problems, conflicts with assigned therapist/case manager, or cultural barriers. Documentation should reflect that all reasonable efforts were made to resolve these matters prior to termination including contact with consumer's referents.

6. If a RSN Clinical Care Manager denies termination of care for a consumer with circumstances identified in Section 1, the provider will continue serving the consumer as documented in the individualized treatment plan. If the provider does not agree with the denial of termination, the provider should gather more information for clinical rationale of the termination and then conduct an informal review of the denial with the involved RSN Clinical Care Manager.

7. If the Clinical Care Manager denies the termination of care after informal review, the provider should then initiate the RSN procedure for Denials of Service Authorization and Appeals. In all cases, the provider is to continue serving the consumer per the individualized service plan until the appeal has been resolved.

8. DSHS will automatically disenroll from the Medicaid program any enrolled recipient covered under this Agreement if:

   a) The service recipient becomes ineligible for coverage due to loss of Medicaid eligibility, or
   b) The services recipient's residence for Medicaid eligibility is located outside of the RSN's service area, or
   c) The service recipient dies, or
   d) The service recipient requests disenrollment and establishes "good cause" or a fair hearing decision directs such action.

9. American Indians (as defined by 25 USC 1603) may disenroll from the prepaid health plan and receive mental health services by Indian health service programs or tribal clinics.

10. Tribal members may enroll or disenroll monthly from the prepaid health plan.

Approved By: _____ Date: _____

Michael Piper, Director
Clark County
Department of Community Services